Obesity – An "Acceptable" Prejudice

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Modern society has placed a high premium on good health, a lean body, and comeliness. As a nation we eat better, exercise more, and seek a healthier lifestyle to achieve physical well being. A national consensus seems to exist that a well-proportioned body is a thing of beauty. It is no wonder, therefore, that obesity, a caricature of the beautiful body, has been responsible for ridicule and social ostracism. Not only have obese persons been subject to ridicule, but that ridicule has been socially acceptable. Witness the many cartoons, movies, plays, and books where an overweight person has been made the object of mockery, often without any gesture of sympathy to counterbalance the prejudice. Ridicule of another human being for being obese, or for any other reason, is insensitive and unjustified. Concern about obesity should focus on its debilitating health consequences for the obese individual and for our society as a whole.

Obesity, or the quality of being overweight, has been defined as being 20% or more above desirable weight according to the 1983 Metropolitan Height and Weight tables for a medium-frame person. Another measure used to gauge obesity is body mass index (BMI), which takes into account a person's weight and height. Body mass index is calculated by obtaining an individual's weight in kilograms and dividing that value by the person's height in meters squared. Overweight is defined as a BMI ≥ 27.8 for men and ≥ 27.3 for women.

Morbidly obese individuals are characterized as those persons more than 100 pounds above ideal body weight or those with a BMI greater than 35 and a serious comorbidity or a BMI of 40 without serious comorbidity.[1] Although the prevalence of obesity varies by sex and race, an increase has occurred in the age-adjusted prevalence of those persons overweight within race/sex groups and overall. In the period 1988 to 1991, 33.4% of US adults 20 years of age or older were estimated to be overweight, and perhaps as many as 12 million US citizens are morbidly obese.[1]

Subjects of derision, obese persons have been discriminated against at home and in the workplace. Overweight people have difficulty in obtaining employment. Overweightedness is also associated with many adverse health outcomes and increased risk for mortality. For these reasons, a National Institutes of Health Consensus Development Panel on the Health Implications of Obesity advised that treatments be initiated in patients who are greater than 20% above ideal weight (BMI > 27-28).[2] Similarly, a National Institutes of Health Consensus Conference on Gastrointestinal Surgery concluded that surgical therapy should be offered to morbidly obese patients unresponsive to nonoperative measures for weight loss.[3]

Operative measures for the management of morbid obesity may be divided into 2 categories, restrictive and malabsorptive procedures, both of which can be performed with minimally invasive, laparoscopic means. Restrictive procedures rely on manipulation of satiety to control obesity. Early satiety is induced by the creation of a small gastric pouch. Narrowing the gastric pouch outlet brings about prolonged satiety. Examples of restrictive operative procedures for morbid obesity include vertical banded gastroplasty, silastic ring vertical gastroplasty, gastric banding (LAP-BAND®), and the several varieties of horizontal gastroplasty. Typically, restrictive procedures are not technically demanding and do not result in malabsorption syndromes or vitamin/mineral deficiencies. However, there is usually less long-term, sustained weight loss associated with restrictive procedures because of the possibility of pouch dilatation or maladaptive eating behavior (excessive consumption of sweets).[4]

Malabsorptive procedures for morbid obesity include jejunoileal bypass, biliopancreatic diversion (BPD), duodenal switch, Roux gastric bypass, and long-limb gastric bypass procedures. Circumventing a portion of the small intestine causes malabsorption of food nutrients and subsequent weight loss. Usually a greater degree of sustained weight loss results from malabsorptive procedures than from restrictive procedures, which depend solely on manipulation of satiety for their mechanism of action. Yet, protein and caloric malabsorption as well as vitamin

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and mineral deficiencies can be serious, and vigilant follow-up is indicated for patients who have undergone a malabsorptive procedure for morbid obesity. In addition, diarrhea and steatorrhea are common. Malodorous stool and flatus can be troubling to the patient and socially unacceptable.[5]

Unrelenting obesity is associated with serious comorbidities. These comorbidities include but are not limited to, noninsulin-dependent diabetes mellitus (NIDDM), hypertension, hyperlipidemia, obesity hypoventilation syndrome, degenerative joint disease, cardiovascular disease, cholelithiasis, and sleep apnea. All of these comorbidities may be improved with weight control.[6,7] Perhaps even more important is the fact that obesity is a significant contributor to mortality in the United States and may account for as many as 300000 deaths per year, or 14% of all deaths.[8]

Because of these very serious concerns and because morbid obesity is a disease and not a preference, it is time we accorded this tragedy the importance that it deserves. It is no longer enough to merely send these patients to a "fat doctor" or to a psychiatrist. It is no longer tolerable to discriminate against those who are obese and sustain the "acceptable" prejudices of the past. Obesity, particularly morbid obesity, is a very personal problem. But morbid obesity is also a societal health problem that has many and multifaceted ramifications. Some long-term health problems like NIDDM can be cured and many others alleviated. Even mortality may be reduced with appropriate surgical intervention.

Physicians, particularly laparoscopic surgeons who have currency in advanced procedures, need to be aware of the magnitude of this disease and need to be capable of intelligently discussing the issues with their patients. Bariatric surgery can be performed with laparoscopic techniques. Those not involved with bariatric surgery can counsel their patients regarding the options available and the most appropriate places to seek treatment. Regardless of our prejudices regarding obesity, it is time to get involved and change the status quo.

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Consensus Statement

The editor wishes to acknowledge that a number of surgical journals have recently published a consensus statement[1] for submission of publication of manuscripts. We at SLS are especially pleased to see this as we have fostered such an approach from the inception of the *JSLS*. Our guidelines are based on the AMA recommendation found in the *Manual of Style*, published most recently in the 9th Edition.[2]

1. Consensus statement on submission and publication of manuscripts. *J Am Coll Surg*. 2001;192:A49.

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